Questions from December 15, 2004 Cost Containment Presentation and January 6 – 9, 2004 Cost Containment Trainings

Please refer to recent bulletins for clarification to many issues related to Cost Containment. If you have additional questions, direct them to the BDDS Help Desk at bddshelp@fssa.state.in.us.

AFC (Adult Foster Care)

1. For AFC clients who require total care who now receive RHS, will there be any type of replacement services to assist householders?
   No. Anyone receiving AFC should not be receiving RHS. The AFC is the Residential Service and provides all the residential supports for the individual

2. Is AFC using daily rate?
   Yes, the monthly rate for AFC will become a daily rate effective March 1, 2004.

3. What changes in documentation requirements will accompany changes in AFC/CFC to daily rates?
   There have been no changes to the documentation standards.

BMAN (Behavioral Support Services)

1. Would it be considered to discontinue the BMN1 service which was added at the same time as CHIP & CETA (Rather than limiting the direct client services when BMN1 is the behavioral specialist meeting with HSPP & not client)?
   There are no plans to discontinue the requirement of a BMN1.

2. Is a behavior plan required for a person using psychotropic meds if the person's needs are being adequately met through a psychiatrist/physician?
   If an individual is on a psychotropic medication for a psychiatric diagnosis and is being successfully treated by a psychiatrist/physician a behavioral support plan is not required; however, the behavior support needs of the individual would need to be determined by the Individual Support Team. If an individual is on a psychotropic medication specifically as a restrictive measure for controlling behaviors, then a behavioral support plan is required.

3. Can behavior mgmt go into the school system under waiver dollars? Historically DOE should be funding this.
   If an individual is being served on the waiver and has behavioral support services, attends school, the behavioral support services should be consistent for individual throughout his/her day. This may require the behavioral support provider to consult with school in order to promote consistency.

4. Is BMN1 included in the six hour cap? You reference "consultation with HSPP" as a task within the BMAN service, does this mean BMN1 will be eliminated?
   No. The HSPP is BMN1.

5. Does the 6 hour guideline for behavioral support services apply to both BMAN and BMN1?
   No, the 6 hours applies to BMAN only.

Respite

1. Can families be reimbursed for "summer camps" through respite funds? As in the past?
   No. Camp fees are not included under Respite services.

2. Can respite nursing be provided in a family home in order to allow family member to work?
   No. Respite must not be used for a family member to work (1/9/04).

3. Please clarify sleep staff for individuals that use respite for family members. Example: parents use respite for a 24 hour period for an out of town trip. Are staff expected to stay awake for the total period? Does the policy that staff not sleep only pertain to RHS and those receiving 24/7 shift staff?
   The respite provider can sleep while providing the 24 hour respite, if the family sleeps while the individual sleeps. If a member of the family does not sleep while the individual sleeps, then the respite provider/staff needs to plan to provide the supervision that the family provides.

4. Respite – 2 clients – both on 10 hours each respite monthly. Caregiver takes care of both at the same time (family's preference). How do we bill? One-half to each client?
   Yes, split the billing/hours between the two.

5. Respite – 10 hrs monthly for everyone. What about people who had 100 hrs. Monthly? Will the balance of 90 hrs. be converted to another service?
   No

PCP (Person Centered Planning)

1. PCP facilitation provider – do the qualifications previously required still apply or has that changed? Is approved training sufficient or does the person still have to document that they have observed and participated in PCP meetings?
   There have not been any changes to the certification requirements. Individuals must submit documentation to central office as evidence of approved training which includes the observation and participation time.

2. PCP facilitation reimbursement rate – what about individuals who do not qualify for a waiver, or who are on a waiting list for a waiver? Can we bill Title XX for the 6 hrs/year of PCP facilitation?

   No. It is the responsibility of the BDDS Service Coordinator to ensure that the ISP is completed using a person centered planning process; however, the provider may be the one who is actually completed the documentation. There is no reimbursement for providing this service outside the waiver.

3. Is PCP facilitation in addition to CMGT, if CM is doing the facilitation?

   Yes

4. With the Service/Cost caps, this then "null & voids" the PCP process and ISP plus consumer choice?

   Absolutely not. The person centered planning process is more than identifying what can be funded with the Medicaid Waiver. Other resources should be identified and pursued as well.

5. Why does a community based agency have to apply to be a PCP facilitator when CM's do not? Unleveled playing field.

   All entities have the same requirements.

6. Are current CMs going to be auto approved to do PCP?

   No. Case Managers will need to meet the same requirements as any other PCP facilitator.

7. Who is charged with responsibility of PCP/ISP process….waiver CM or day services provider?

   If an individual received waiver services, the case manager is responsible to ensure the PCP/ISP process is completed. The BDDS Service Coordinator is responsible to ensure completion for all others. However, this does not mean the case manager or BDDS Services Coordinator is the one to complete. The individual may choose any of the approved facilitators. Refer to 460 IAC 7-4-3.

8. Does a day services provider have to follow PCP/ISP guidelines for participant who is still using Title XX funding due to not qualifying for SSW?

   Yes. All individuals receiving services must meet the requirements outlined in 460 IAC 7.

9. Explain the 3 hr. CM restriction and where it applies.

   There is no restriction. The number of hours reimbursed are limited to 3 for Initial/Annual and 3 for updates. If the service does exceed 3hrs, it then becomes a cost of doing business.

10. We've had difficulty getting state district service coordinators to attend/set up ISP and quarterlies. They seem to be overloaded with responsibilities but we need copies of ISPs and documentation of quarterlies. What is the plan to ensure providers get the paperwork for ISPs and quarterlies that is required?

The Service Coordinator is responsible to ensure that the ISPs are completed for all individuals receiving services. However, this does not mean the Service Coordinator is the one to complete. The individual may choose any of the approved facilitators. Refer to 460 IAC 7-4-3.

Screening/Assessment

1. What is that status of the screening device?

We will resume looking into it over the next month. We will pilot the process; updates will be discussed regularly with the waiver task force team.

2. What will be the status of CM in determining HCC for each person?

There is currently a team looking at the HCC process. An assessment tool is being developed to help determine the need of HCC services.

3. Will licensed professionals now be removed from professional liability since CM and screen denial will decide HCC.

No.

SSW (Support Services Waiver)

1. According to the CHP definition, there is no cap for the Support Services Waiver. The only cap listed is for Title XX, but not for the SS Waiver. Is this correct?

There is no cap on CHP for Support Services Waiver. Six hours per week will continue to be used for a guideline, in particular, for those how have transferred from Title XX to the SSW.

2. As a day service provider, the only billing category we have for day services to make up for the decrease in res hab will be CHPI, group or individual…. Individual is capped at 6 hrs/mo and group hab is ratio 8:1 and $15.34/hr reimbursement. How can we be expected to serve higher support need waiver individual in day services at this rate and staff ratio? We simply can't serve at this rate. Adult Day Services (prev. day care) is also a poor reimbursement considering the additional costs of full-time nurse and provider of meals and snacks. Help us! Providers will provide day services, but we must be able to pay for our facility needs and increase staff ratios to do this!!

We are reviewing the needs of the day service providers. The state must also meet its financial obligations. We must all work together to find alternative ways to meet the needs of the individuals we serve.

3. Is there a plan to release the SSW slots for FY 05?

No, not at this time.

4. Will any of the waiting list for SSW be reduced in April 2004 when the waiver was originally written to release the final 2333 slots?
   No.

5. What is going to happen to the consumers who are on the SS waiver, who live alone, and who are only receiving CHPI and CETA? These individuals cannot receive RATT since they live alone. These individuals will only use TD1 service on the SS waiver. These individuals do not have the options of RHS service on the SS waiver. What good will the SS waiver be to these individuals who live alone?
   There are other services on the SSW that may be accessed. All the CHP services are available, in addition Supported Employment, Pre-Vocational Services, etc. A PCP and ISP need to be completed to determine the needs of the individual.

6. Is it my understanding that all CCBs must be resubmitted because they now require a service planner? If so, are the CCBS due by the dates provided (Jan. 21-28)?
   If you are submitting a CCB for the Support Services Waiver for ANY reason for services beginning or continuing from March 3, 2004, a Service Planner must be attached. (The only exception is for updates to plans that end on or before 2/29/2004.)

Daily Rates

1. What do you mean by "elimination of day rates"?
   There will be no more RHS daily rate to be billed.

2. How does eliminating the daily rate going to save money?
   Services being billed will be billed according to actual use.

Transportation

1. If a person can be left alone for 2 hrs pr day, are they no longer considered 24 hour and no longer qualify for $150.00 mileage? They still need it!
   If a person is no longer in need of 24/7 supervision (can be independent for 2 hours per day), they would no longer qualify for the $150.00 monthly amount. They would, however, qualify to receive the round trip rates of $8.91 and $2.00.

2. Has BDDS considered removing the current "provider - UNFRIENDLY! Method of billing transportation and considered setting maximum for units and billing per Medicaid Provider Rules (units and odometer readings) vs. flat rate $150.00/300.00 for clients who do not always utilized these amounts. Could save enough money for these folks to give up the current b.s. method being used. Providers are currently resistive or not billing at all for transportation and billing RHS instead which is a higher rate.
   Transportation is not being revised at this time.

3. Individual requires 24 hours approved for RHS in ISP, do we bill $150 per month or per trip?

   $150 is a per month rate.

CHP (Community Habilitation and Participation)

1. CHPI – Will residential providers be able to get a Title XX contract to provide CHPI?

   To become a provider of Title XX services, a potential provider would need to apply to the State.

2. Please clarify accessing Title XX CHPI for DD waiver and ICLB recipients. Is this limited to CHPI only?

   An individual on waiver services must access CHPI via the waiver and this service cannot be supplemented with Title XX funds. If someone is on the ICLB, the CHPI services(to be provided by the residential provider) may be included on the ICLB up to 25 hours per month. The residential and day service providers will need to communicate on the use of CHPI funds. If these services are on the ICLB, then additional CHPI cannot also be billed on Title XX.

CETA (Community Education/Therapeutic Activity)

3. I have clients that use the CETA funding to attend summer camp each year. What funding source can be used to substitute for the CETA funding?

   The teams will need to come together in conjunction with their local BDDS office and find other community supports to attend camp, i.e. scholarships, grants, etc.

4. With the elimination of CETA, will an RLA increase cover services encouraged/added by the case manager that will now not be paid? For example, an individual signed up for a health club membership, but the full approved amount of CETA will not cover the cost, and now there will be no CETA. The individual has a contract he must fulfill, but cannot afford, will an RLA cover this?

   The team will need to strategize how this will be covered for the remainder of the contract by other available funds. If assistance is needed with the health club in order to get out of the contract, please contact your local BDDS office.

Audit

1. Com Hab definitions: How will new definitions be implemented for audit? How will audits know definitions have changed and when the change was effective?

   New definitions will be shared with both EDS and State audit with the effective dates of 3/1/04.

Housemates

1. If they apply for Section 8, will it allow them to remain single HH?
   We still need to look at the service costs associated to support the individual. Refer to the RHS household guidelines.

2. Will single person HH w/RLA need to find roommates in order to remain eligible? We have consumers receiving RHS that have lived in their own apt. for many years. Will they be required to get a housemate?
   If an individual remains under the RHS limits, he/she may not need a housemate or additional housemate. Exceeding the RHS guidelines would need to be reviewed by the Exception Review Team.

3. What if guardian refuses to allow roommate within their child's home or rejects roommates of any kind?
   The RHS costs need to stay within the recommended limits. Any requests to exceed these limits will be reviewed by the Exception Review Team. If exceeding limits is deemed to not be justified, it could result in the denial of a CCB or ICLB.

4. Who absorbs cost of vacated* and leased property and moving expenses when 2 roommates move in together? *early term of lease penalties.
   Each case would be reviewed on a case-by-case basis to determine how the costs should be paid. A RLAS may be an option.

5. Comment on the house mate issue – is it a requirement or a suggestion? For example, if an IAS recipient has always lived alone, can he continue to live alone?
   If an individual is within the cost containment guidelines, a housemate would not be necessary.

ICLB/CCB PROCESSING

1. How many increases of 10% will be allowed? For example, if we do an update to a plan of care in the middle of the plan and make a 10% increase, when we do an annual plan of care will we be allowed to make another increase of 10% or is it only one increase per client for their time on the waiver?
   Increases in budgets will not be allowed if there are not health or safety issues involved. There may be some services that would be exceptions, such as Environmental Modifications, Supported Employment, PCP Facilitation -- all would be reviewed on a case-by-case basis. Any increase will be reviewed based on the last approved CCB/ICLB as of 9/11/03 or the Annual CCB/ICLB.

2. I submitted a CCB for a T05 client in August for 2003. I haven't received any response concerning the CCB. When can I expect to learn the status of the CCB?
   T05s are not being processed at this time. If an individual was on an ICLB, the ICLB should continue until further notice.

3. Is the new ICLB form to be used only as the ICLBs come due throughout the year or when the revisions are made? OR is the new form required for everyone at 3/1/04?

   For those ICLBs which contain services that are affected by the Cost Containment issues, they are needed to be revised with the new ICLB form beginning 3/1/04. For those ICLBs that are not affected, they will be acted upon on the annual dates.

4. When will electronic ICLB submission be available?

   The form is available now on the website www.in.gov/fssa/servicedisabl. Providers can submit by email as of March 1, 2004. The ICLBs submitted are for those services that start on or after March 1, 2004. No services prior to March 1st should be included with the electronic submission or paper submission on ICLB form 200403.